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May 2007

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THE EFFECTS OF MOOD DISORDERS ON FAMILIES AND THEIR WELL BEING

A project based upon an independent investigation, submitted in partial fulfillment of the requirement for the degree of Bachelor of Arts in Social Work

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2007

### *Introduction*

Like most illnesses, mood disorders or depressive disorders do not fit into cookie cutter outlines. Depression is individualized to each person and can range in severity. These disorders affect not only the mind, but the body and thoughts of a person. The symptoms can affect every part of a person's life from their sleep cycle, to their eating habits, to their social support network. These disorders can be extremely disabling and in many cases can inhibit the person's ability to live their life freely. Despite the popular stereotype, a person is not just able to forget how they are feeling and cheer up. A depressive disorder is not just someone having a bad day or feeling down.

These are things that this writer has learned and experienced since beginning her ventures into the world of social work. Working within a family agency one can not but help witnessing clients who suffer from disorders like these, who are in many cases struggling daily or unable to live a normal life due to their mental well being. This becomes a more frightening thought when considering that so many parents are plagued with these illnesses, not only affecting their own health and condition, but the overall welfare of their families. Many of these families have few resources to turn to; either because of broken ties and lack of energy due to their disorders or because in many cases services are unavailable or extremely limited to these populations. Mental health is not given enough attention in healthcare; which in part is due to many things. One major difference between mental health and physical health that limits the awareness of the former is the burden of the stigma it still carries in our society. Even after so much research has been done and data has been compiled it is still an area of health not given the proper attention it deserves.

According to the National Institute of Mental Health's website nearly 9.5% of the United State's population or about 20.9 million American adults experience a depressive illness in any given year. "By the year 2020, the World Health Organization estimates that clinical depression will be the second most common cause of morbidity (Puckering, as cited by Gopfert & Seeman, 2004, p.172)." This paper will explain exactly what each disorder entails in order to help the reader understand what someone inflicted with one of these disorders deals with in their daily lives. There are several forms of depression that are named in the DSM IV manual. For the purpose of this paper the focus will be on a few of the more general types of disorders. Information will also be used from the National Institute of Mental Health's website (NIMH). This paper will also focus on the perceived effects that depression has on the family system. Using information from experienced social workers, data will be collected about how having a parent who suffers from a depressive disorder affects their abilities to care for themselves and their children. Being a parent is a difficult job, but it is even more difficult when one's health is suffering and the proper assistance and services are not available. This and many more reasons is why this paper hopes to shed light on the nature of the struggles parents with depression go through in their capacity to take care of their children.

### *Literature Review*

The DSM IV manual describes Major Depressive disorder as “characterized by one or more Major Depressive episodes (i.e., at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression) (2000, p. 345).”

The NIMH website describes some of these symptoms; which include:

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex
- Decreased energy, fatigue, being "slowed down"
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening, or oversleeping
- Appetite and/or weight loss or overeating and weight gain
- Thoughts of death or suicide; suicide attempts
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

Symptoms of a Major Depressive episode usually develop over a time span ranging from days to weeks. There can be a “pre” period when mild symptoms will be experienced prior to the actual onset of the episode which varies in duration. An untreated episode generally lasts for four months or longer depending on the person (DSM IV, 2000, p. 354). A lesser form of Major Depressive disorder is Dysthymic disorder, which is “Characterized by at least 2 years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet criteria for a Major Depressive episode (DSM IV, 2000, p. 345).” The difference between these two

disorders is onset, duration, persistence, and severity. Dysthmic disorder is more long term and chronic, interfering with a person's life but not necessarily disabling it.

A less prevalent form of depression and the disorder that originally stimulated the research for this paper is known as Bipolar disorder. Also known as Manic-Depressive illness this disorder is "characterized by cycling mood changes: severe highs (mania) and lows (depression) (NIMH website, 2006)." The mood shifts are usually gradual but in severe cases can be very sudden. What makes this particular disorder so distressing is that the person is dealing with two opposing genres of symptoms; as if one disorder was not enough. When the person is in the low part of the cycle they can experience all of the symptoms of a depressive disorder and while they are experiencing the high part of the cycle they are prone to manic episodes and the accompanying symptoms, which according to the NIMH website include:

- Abnormal or excessive elation
- Unusual irritability
- Decreased need for sleep
- Grandiose notions
- Increased talking
- Racing thoughts
- Increased sexual desire
- Markedly increased energy
- Poor judgment
- Inappropriate social behavior

"Bipolar I disorder is characterized by one or more Manic or Mixed episodes, usually accompanied by Major Depressive Episodes," while "Bipolar II disorder is characterized by one or more Major Depressive episodes accompanied by at least one Hypomanic episode" (DSM IV, 2000, p. 345). A Manic episode is a period of time lasting at least for

one week when the person is abnormally elevated, expansive, or irritable. This period of mood change must also be accompanied by at least three symptoms of Manic behavior like the ones listed above (DSM IV, 2000, p. 359). One of the difficulties of this disorder; especially when someone is experiencing a Manic episode, is that the person frequently does not realize they are having an episode and resist any assistance to seek help. They might make decisions that are impulsive, lose contact with loved ones, threaten others, have difficulties with the law, engage in out-of-character behavior, and so on (DSM IV, 2000, p. 359). Often the person regrets decisions they made while in this state of mind. Often a Manic episode will occur simultaneously along with a Major Depressive episode; if these symptoms occur for at least one week then the person is considered to be experiencing a Mixed episode. A Hypomanic episode is a less severe form of a Manic episode and is “defined as a distinct period during which there is an abnormally and persistently elevated, evasive, or irritable mood that last at least four days...must be accompanied by at least three additional symptoms” (DSM IV, 2000, p.365). The symptoms are the same criteria used to describe a Manic episode, but delusions or hallucinations cannot be present.

One final depressive disorder to mention is the depression experienced by mothers after childbirth. According to Puckering, “One to two women in every 10 will suffer a depressive disorder after childbirth” (Gopfert & Seeman, 2004, p.172). What makes postnatal depression so significant is the complete dependency of the infant on the mother. “The (depressed) parent is the primary environment of the young child” (Gopfert & Seeman), 2004, p.176). The child’s world revolves around the attention and care they receive from the primary caretaker, so when the caretaker’s abilities are inhibited by

depression, normal behaviors and attachment do not take place. Specific risk factors for postnatal depression include depression during pregnancy, the “baby blues (common period of a few days following birth)”, poor perceived parental care in childhood, unplanned pregnancy, unemployment, depression in the partner and having two or more children (Gopfert & Seeman, 2004, p.173). What makes this disorder more difficult is the lack of recognition that these women need help. With any form of depression, often people do not recognize their own symptoms and do not seek aid, but when women experience postnatal depression it becomes worse. Some women do not seek assistance because they fear to admit their inadequacy as a parent, afraid that they may be seen as an unfit parent. Another reason is that she may dismiss her feelings, attributing them to the new stressors caused by the baby; for example lack of sleep and a demanding infant. These barriers prevent new mothers from seeking the help they really need because they are unable to recognize the seriousness of their condition (Gopfert & Seeman, 2004, p.174).

These disorders all are defined by specific criteria, but for the purpose of this paper a general understanding of what is involved will suffice for the reader to understand the impact that such an illness can have on not only the person directly experiencing the symptoms but the surrounding loved ones who indirectly experience the disorder as well. Many of these disorders also come hand in hand with other mental illnesses making the illness more complicated and harder to diagnose and treat properly. Another problem with treatments is that many people do not seek help although there are treatments available either because they have a lack of resources or possibly because of symptoms of their own disorder.

Another stressing characteristic of mood disorders is that the exact causes are unknown. There are many ideas about how these disorders originate and many treatments exist that can help some people, but many cases still remain a mystery. One cause that gets a lot of attention is the genetic predisposition to the disorder. There is believed to be a biological vulnerability that runs in families; this is seen in many cases with bipolar disorder as well as others. According to the American Psychiatric Association (2000) close relatives of people suffering from Bipolar disorder are ten to twenty times more likely to develop some sort of depressive disorder. If one parent of a child is suffering from a depressive disorder the child has a 12-15% chance of suffering from one as well. If both parents are suffering from a disorder then the risk increases to a 25% chance. There is believed to be a change in the genetic makeup that makes these disorders inherited, but not everyone with the genetic change ends up with the disorder, so additional factors are believed to influence the onset of a Mood disorder. One factor is personality traits of the individual. People who are characteristically more pessimistic, have low self-esteem, and are easily overwhelmed are more prone to depression. It is unclear whether their personalities represent early symptoms of the disorder or if there is a psychological predisposition. Like many other factors it becomes the question of what came first; the chicken or the egg; the disorder causing the symptoms or the personality causing the disorder. Another factor is physical changes. Medical illness or changes in the body can be accompanied by mental changes as well. Also the onset of a serious stressor/s in a person's life can bring on a depressive episode such as a serious loss, financial problems, or adjustment to a large change. Often it is found that "a combination

of genetic, psychological, and environmental factors is involved in the onset of a depressive disorder (NIMH website, 2006).”

There are also gender differences found in Mood disorders. According to the National Institute of Mental Health (2006), women are twice as likely to experience depression as men. This is believed to be true due to hormonal differences between the two genders (women experiencing menstrual cycles, pregnancy, menopause) and other life stressors that typically effect more women than men, such as sex role expectations, single parenthood, lower income, and more. Another factor that makes women more vulnerable to depression is their role as mothers. Many women experience post partum depression following the birth of their babies. Men are less likely to suffer from depression, but there are factors involved such as men being less likely to admit to their problems and doctors being less likely to suspect anything is wrong that might influence these statistics. The NIMH approximates that nearly 6 million men in the United States are affected by a depressive disorder. Also men are four times more likely to commit suicide than women. There are gender role expectations in our society that make it more difficult for men to be open with their feelings. Our society demands a strong man who is not helpless or sad, so men often show their depression in other ways such as anger or frustration and mask their feelings with something else such as substance abuse problems (this of course could also occur in women). Unlike with most Mood disorders, Bipolar disorder is found to occur equally among men and women (DSM IV, 2000, p.385). The However, men tend to experience more Manic episodes than Major Depressive episodes while women experience more Major Depressive episodes over Manic episodes. Women

are also more prone to Rapid Cycling (the occurrence of four or more Mood episodes in a twelve month period) (DSM IV, 2000, p.427).

For such prevalent disorders it seems like not enough attention is given to the grievances they cause people and their loved ones. This paper focuses on the effects of Mood disorders on the person with the disorder and those around them, especially in the case of parents and their children. According to L'abate there are three key factors involved in parenting style; which includes the warmth factor, the control factor, and the consistency factor (1998, p. 159). The warmth factor refers to the degree of emotional warmth in the parent-child relationship, or how supportive or unsupportive the parent's behaviors are towards their child.

Supportive behaviors include "praising, approving, encouraging, helping, cooperating, expressing terms of endearment, and physical affection"...Nonsupportive behaviors include blaming, criticizing, punishing, threatening, ignoring the child, and expressing anger and negative evaluations of him or her. (L'abate, 1998, p.159)

Through the examples of parental behaviors becomes clear why the warmth factor is directly connected to a child's self esteem. The next factor, known as the control factor involves two variables: the frequency of control and the style. Parents who lean more towards the frequency variable have many rules and a strict adherence policy, taking opportunity to intervene in their child's life frequently. On the opposite end of the spectrum the parent is extremely permissive, even to the point of neglect. The style variable also exhibits two poles: on one end the parent has the absolute right to "evaluate and direct the child" (L'abate, 1998, p.160) and at the other the child has the right to answer back to his or her parent. With both of these variables the extreme ends of the spectrum have been presented, and it should be understood that the proper parenting is

found somewhere in the middle for both of them. The last factor involved in parenting is the consistency factor. This involves the degree of coherence and consistency in the communications, discipline, expectations, family values, and attention that is displayed in parenting. The child's performance will be affected by how consistent the parent is; for the most part the child needs a stable environment, where they feel safe and understand their surroundings (L'abate, 1998, p.160).

Psychiatric illnesses and the symptoms they produce tend to undermine an individual's parenting ability and leads to suboptimal care of children (Seeman & Gopfert, 2004, p.12). For example, a parent's mood fluctuation, their decreased tolerance levels, or possibly the increase threat of physical harm could all contribute to their parenting deficiencies. In severe cases children might have to be removed from their parent's custody due to their inability to parent appropriately and fulfill the needs of their child. According to Seeman & Gopfert, families also have to deal with the shame and stigma of mental illness, which can cause the family's isolation and limit the healthy development of the children (2004, p. 13). Children also have an increased risk of developing a disorder themselves if their parents have a psychiatric disorder. Other risk factors associated with childhood disorders include: single parenthood (twice as common), separation, divorce, current marital discord (39 vs.8 %), admission to care, parental criminality, large family size, overcrowding and an unskilled or semi-skilled breadwinner (Rutter & Quinton, 1984, as cited in Seeman & Gopfert, 2004, p.22). Hall goes on to discuss how studies support the notion that conduct disorder in children is associated with their experiencing or witnessing of violence or aggression as well as poor parenting skills, all of which are more commonly seen among psychiatric patients as

opposed to the general population (Rutter & Quinton, 1984 and Kuperman et al, 1999, as cited in Seeman & Gopfert, p. 24).

Another effect on children who have mentally ill parents is that in some cases there is an increased level of physical harm for the children. In the United States there are between 2000 and 5000 children killed by their parents (Lung and Daro, 1996, as cited by Seeman and Gopfert, 2004, p.24) and neglect accounted for 37% of deaths of children in 1996. D'Orban did a study (1979) which produced results that have been retested and found to be accurate more recently. His studies were on the influence of mental illness in relation to parents who were responsible for killing their children. Here are some of his findings:

D'Orban found that 27% of women were mentally ill when they killed their children...Although the majority of the women in D'Orban's study were not considered mentally ill at the time they killed their children, 41% had previously received psychiatric treatment, a quarter had a parent with mental illness and 43% has a personality disorder. Most often, they killed their children impulsively during an outburst of temper. They came from disadvantaged backgrounds: 61% had been separated from one or both parents as a child and 21% has experienced abuse (1979, as cited by Seeman and Gopfert, 2004, p.25).

Risk factors for fatal child abuse such as domestic conflict or violence, pregnancy or recent birth, housing and financial difficulties are commonly seen with socially disadvantaged parents with mental health problems (Seeman & Gopfert, p.26). Mental health providers need to pay attention to these kinds of warning signs as well as other risk factors. In a more recent study done by Brown and Herbert, they found that "parents with a history of mental illness or substance misuse were seven times more likely to abuse or neglect their children" (Brown & Herbert, 1997, as cited by Seeman & Gopfert, p.26). The risk increased when there was a history of family violence, when parents themselves

had experienced abuse or neglect as children, and when the parent was indifferent or overanxious towards the child. These risks all indicate unstable parenting behaviors. For example the parent either does not care enough about the child or is over protective and suffocating. Taylor et al, who studied the court records of seriously abused children in Boston, Massachusetts, found that:

In 84% of cases one or both parents suffered from a psychiatric disorder or had IQs less than 80. 64% of the mothers suffered from a psychiatric disorder, with major depression or schizophrenia accounting for 42% of the diagnoses. Fathers had high rates of schizophrenia, personality disorders and severe depression (Taylor et al, 1991, as cited in Seeman & Gopfert, 2004, p.26).

These findings are of course from extreme examples of severe impairments by mental illness. This is not to say that if someone has a mental illness then they are immediately a serious risk to their child. These studies are meant to be examples of more extreme cases of what can happen to a minority of people with mental illness if the illnesses are severe, persistent, untreated, and involve many risk factors.

Now that we have reviewed some of the more extreme problems, let us move to focus on how a mental illness such as depression might influence parenting technique and influence children as they grow. Many studies have shown that there are associations between particular psychiatric disorders in parents and impairment of attachment in infants. “Children of mothers with psychiatric disorders are more likely to show anxious or avoidant attachment in the second year of life. The attachment may become secure if the child has the opportunity for an improved relationship later” (Ainsworth et al, 1978, as cited in Seeman & Gopfert, 2004, p.28). Another study done by Murray showed how infants with post-natally depressed mothers lack strong, secure attachment to their mothers, performed worse on tasks, and demonstrated mild behavioral difficulties

(Murray et al, 1992, as cited by Gopfert & Seeman, 2004, p.29). These kinds of signs so early on demonstrate how it is not only the mother who will need help and support in handling the disorder but the child as well. The mother-child relationship has been damaged and needs repair. Too often the focus is solely on the parent, but problems will still persist for the children who are affected by the parents' behavior. Parenting style will affect the child's behaviors and how they form relationships with others. Their personalities will be affected. For example one study found that "withdrawn depressed mothers had more vocal demanding children while the children of agitated intrusive mothers were often tense and withdrawn" (Weissman & Paykel, 1974, as cited by Gopfert & Seeman, 2004, p.29). Attachment and how the child is developing are important because these early stages of development have a huge impact on how a child will grow and mature.

Lomas has suggested that depression in a parent can lead to a poor psychological environment for a child due to inadequate physical contact with the child; the diminished ability of a parent to understand reality; the lack of emotional response in a parent which will discourage a child from expressing or receiving emotion; and lack of a good model for ordinary patterns of behavior (Orford, 1987, p. 204)

In serious situations questions arise of whether a parent is fit to care for their child. If they are not supplying adequate care and support for their child and lack a healthy attachment, then the child is at risk. These are some of the situations that occur when children need to be removed from parent's custody. As the children grow to be adolescents and young adults problems may persist and become more extensive. In a study done by Carlson and Weintraub in 1993 they found that "over half the children of mentally ill parents had significant disturbances as adults (Gopfert & Seeman, p.34)." Mostly the problems were affective disorders and substance abuse. Another study done

by Beardslee et al in 1998 “showed that children of a parent with affective disorder have a 40% risk of a major depressive episode by the age of 20 (Gopfert & Seeman, p.34).”

This is just to name a few of the findings on the effects on children.

Having a parent who suffers from depression is not the sole determining factor on how the child will develop; there are many other factors involved that are interrelated. The developmental model diagrams these relating factors that contribute to the child’s resilience or vulnerability when faced with adversity (Gopfert & Seeman, 2004, p.34):

*Please see diagram #1*

First to discuss are the constitutional factors or the factors that children are predisposed to from birth. As seen on the diagram these include intelligence, temperament, genetic endowment, gender, pre/perinatal adversity, and physical attributes. Children with higher educational abilities are able to find solace in school and succeed; while children who are impoverished and have lower IQ’s are more prone to be affected by negative family attributes. A child’s temperament affects the interactions they will have with the parent. They could be an easy child or a more difficult one; which would cause more stress on the parental figure. Certain characteristics such as social responsiveness allow the child to find better ways to cope. As far as gender is concerned girls are more likely to develop depression if the mother is depressed (as opposed to boys) and more likely to suffer from emotional disorders (Gopfert & Seeman, 2004, p.36). Genetic endowment is another factor involved. “Rutter et al. (1990) conclude that there is little evidence for a major genetic contribution in child psychiatric disorders, apart from early-onset major depressive disorder (Price et al., 1987; Puig-antich et al., 1989) and bipolar disorder (Akiskal et al., 1985; Strober et al., 1988)” (Gopfert & Seeman, 2004, p.36). Prenatal

and perinatal adversity refers to the care the child is given while still in the mother's womb and the effects it has later in the child's life. According to Gopfert & Seeman mentally ill mothers are less likely to seek antenatal care and more likely to have unplanned pregnancies. They are also more prone to partake in health risks such as smoking, drug use, and improper diets while pregnant (2004, p.37). Women with behaviors while pregnant run a higher risk for health problems in their children, including fetal alcohol syndrome or premature births. Finally, physical attributes can play a part in predisposing the child to risk due to their appearance, illnesses, or handicaps. Any negatives seen in the child can lead to them being rejected or criticized by parents.

The next set of factors involved in whether a child is at risk are perpetuating factors; which are effects that will be constant in the child's life. The early mother-infant relationship has a powerful effect on how the child will begin to develop. If the mother (I will refer to the mother only because she is more often the primary parental figure) does not provide proper care and fails to form an attachment with the baby that infant can go on to suffer from what is known as failure to thrive (Gopfert & Seeman, 2004, p.37). Failure to thrive is a condition involving several factors including falling below the fifth percentile in weight and height (that means that child is below 95% of other children), and displaying delays in psychomotor development (Crosson-Tower, 2005, p.77). If the child is not able to form a secure attachment with any adult then there will be detrimental results on the child's overall development. Children of mentally ill parents are also more likely to experience separations from their mother because she would be vulnerable to illness after giving birth (Gopfert & Seeman, 2004, p.38). Other factors to consider are socio-cultural factors. If a stable extended family is present that can provide support,

then this can protect the child from troubles with a parent. Also strong, healthy relationships with adults and close friendships influence a child's ability to cope. Finally we get to familial factors. How well the family functions together and adapts is a predictor of problems.

Warner et al. (1995) found that chaotic family environment was an independent predictor of mood and panic disorders in children of parents with major depression and panic disorders...Patterson (1982) showed that indifferent, uninvolved and neglectful parenting tended to increase aggression, low self-esteem, poor self-control and disturbed parent-child relationships in the children. The parent tended to issue more commands while failing to follow through with discipline or praise good behaviors. This style of parenting is more likely to occur when a parent is ill...(Gopfert & Seeman, 2004, p.39)

The final set of factors involved is known as precipitating factors. These include major life events and the current family psychopathology. The children of those with mental illnesses more often will be exposed to negative life events such as being separated from their parent, marital breakdown, deaths, and poverty. Children who experience these types of events are known to be influenced by them throughout their development and into their adulthood. For example, Gopfert and Seeman give an example of a study done by Goodyer et al in 1993 that found that "Girls aged 11-16 years, whose mothers had a history of psychiatric disorder, especially depression, and who were exposed to one or more undesirable events were especially at risk for depression" (2004, p. 39).

Another framework that demonstrates the interconnected relations between depression and family is given to us by Judy Garber;

*Please see diagram #2*

This biopsychosocial framework displays the influencing paths that these negative effects can take. For example people with certain temperaments (which is a result of genes and environmental factors) such as neurotic for example, are more likely to perceive stressful life events as threatening, and will respond with negative behaviors ( Depression) (Judy Garber as cited by, Hudson & Rapee, 2005, p. 227). In turn the depression will affect the family relations, creating damaged familial relationships, and more stress for the family.

These two outlines demonstrate the effects that not just a single factor but multiple, intertwined factors have on a child's life. When trying to pinpoint exactly what will be detrimental to a child's development all of these things need to be considered because there is no lone cause. How a child will respond to their mentally ill parents depends on many things. Although it seems evident that a child will be affected by their parent's illness, without considering all factors involved it can not be understood how well the child will be able to cope and continue to develop unhindered by the stresses and adversities the illness may bring. Garber mentions:

Parents and children mutually influence each other; their relationship is dynamic, transactional, and reciprocal...Parental depression may have dysfunctional effects on the quality of the mother-child relationship, elicit various forms of child maladjustment, and over time, such child behaviors in turn likely provoke and maintain negative maternal attitudes and behaviors toward the child (as cited by Hudson & Rapee, 2005, p.249).

Garber goes on to summarize the effects that will influence the transmission of psychopathology to the child of a parent who suffers from depression. First since the child and the parent share common genes they will both have similar biological sensitivity. Second it is important to realize that a depressed parent's attitudes and behaviors will influence the child because the child will learn these social behaviors

through modeling their parent, in effect adopting the negative behaviors and maladaptive reactions to the stress that their parents suffer. Next the parent's symptoms from their illness will undoubtedly increase the stressors of the family, which will affect the child's ability to develop and function properly. Finally we must keep in mind that the child and parent influence one another through their transactions, the child's temperament will affect the parent's attitudes and behaviors. This can perpetuate the disease through extra stress, hurting the child in return (as cited by Hudson & Rapee, 2005, p.252). With relationship cycles such as these (as well as with other family members and friends) it becomes clear why families have such a difficult time trying to navigate through the complex web of influencing factors and intertwined behaviors.

There are multiple factors involved when determining how well a child will endure their environment. Children are vulnerable from birth because they start off their lives learning and taking in everything around them. For the most part their parents will be the biggest influences on their young lives; for these will be the people they model, learn from, and adapt to. If something intervenes and alters the positive relationship and nurturing they need from their parents, then the child will most likely feel the consequences of the problem. Parents who suffer from depression have a plethora of stressors to work through and are not always aware of the causes of their feelings or how to seek help for themselves. Through the research in this thesis this writer hopes to determine some of the specific effects that having a parent who suffers from depression has on the children. It is important to realize what is lacking in the children's development and what extra problems they face in order to structure services that will better confront the problem. It is also vital to understand what factors are most influential

in causing the parent stress and how to better help them access assistance. Depression is a multifaceted disorder that affects more people than any of us would imagine. With a disorder such as this that can affect people from the moment they are born and plague an entire family, it is imperative that we learn as much as possible in order to offer better solutions so that our neighbors can have happier homes that offer warmth and care to their offspring.

### *Study Question*

People who suffer from bi-polar disorder or other types of depression experience a range of symptoms and reactions due to the disorder that causes not only themselves, but their loved ones, to experience negative effects. For this thesis, research was compiled that gives evidence to the above statement and demonstrates some of the many effects having a close loved one with bi-polar or depression can have on family relationships. The main focus will be on the parent-child bond; additional information will be gathered on the impact on the marriage bond and overall family structure.

### *Methodology*

#### *Empirical Study*

##### *A) Sampling Plan/Participants*

The sample being used is a sample of convenience for the subjects have been selected from social workers at the researcher's current internship. The sample includes ten social workers who work either in the Comprehensive Emergency Services program or for the Family Outpatient Program, which are both part of Gateway Healthcare Services. CES is a program that provides a wide range of services to at-risk families including support, parenting education, linkage to resources, working with domestic violence issues, child abuse, children at risk, and overall families in crisis. CES is an outreach program which allows the social workers to work with clients in their own homes. FOP is an outpatient program that provides services to similar clientele and is more focused on mental health services. The clientele typically serviced by the participants are families in crisis.

Often there might be a single parent, teen parent, parents in domestic violence situations (or have experienced domestic violence in the past). These clients often have financial restraints, few resources, and little access to support systems.

These families usually suffer from multiple stressors and may have experienced recent or past trauma. All of these clinicians have worked for either CES or FOP from a range of two to twenty years and have received either a BSW or MSW and are professional social workers. All of these social workers have dealt with cases involving mental illness including depression and bi-polar disorder so they have had years of experience working with clients who suffer from these mental disorders. While working with clients these social workers are witnesses to familial behaviors because the programs are interventions for families having difficulties. The focus of the programs are to assist these families helping them to improve their communication skills, problem solving abilities, parenting education, personal relationships, and self-awareness. Due to the personal nature of the program a lot of personal information is divulged to the worker allowing them to witness the effects of problems such as mental illness on family members.

*B) Design/Data Collection*

This study gathered data through a qualitative exploratory study of clinicians' experiences using semi-structured interviews. Data were collected in the form of a questionnaire created for the social workers. The social workers were asked questions in regard to their experiences with clients (confidentiality will be kept) who have suffered with depression or bi-polar disorder. The questions asked the professionals to share and discuss what they witnessed and perceived going on in

families. Questions were centered around symptoms seen in clients, the problems identified with the family, if problems are caused/influenced by the family member with depression, how other family members were affected and so on. The basic strategy for the questions was to begin with more general questions and move on to more specific examples allowing the professional to share their experiences unhindered at first by the topic being discussed (the effects on the family). The interview schedule is found in Appendix A.

*C) Data Analysis*

The main data analyzed focused on examples and information from the experience of professional social workers who handle clients suffering from depression and bi-polar disorder. The information collected was compiled and analyzed for major themes, similarities and differences.

### *Data Analysis*

All of the participants from this research endeavor work in programs oriented to working with and assisting persons who are part of the mental health community. Due to their professional experiences working with these clients they were asked to participate and use their professional knowledge in answering questions related to the effects of mental illness on a person and their parenting abilities. Included in the questions regarding the effects of depression were also inquiries about other problems frequently faced by the clients these professionals work with, to stress the importance of the interconnectedness of life stressors, mental illness, and family disorder.

When reviewing the collected data it became evident that there are many common themes and experiences among the professionals in these organizations. Their practices have introduced them to many of the same situations and they have shared reoccurring themes and patterns found amongst their clients. The purpose of this analysis is to share these findings in order to observe patterns and commonalities plaguing these at risk families.

Before even introducing the topic of mental health to these participants they were first questioned about the major obstacles that their clients face that interfere with their ability to care for their children. There was an overall agreement on many of the obstacles including:

- Lack of parenting skills
- Financial constraints (ex. housing, food, clothing, transportation)
- History of abuse/neglect (parent's past traumatic experiences)
- Mental health issues

- Lack of education/cognitive limitations
- Cultural/language barriers
- Lack of knowledge regarding resources/availability of resources
- Lack of support systems
- Lack of self-esteem, problem solving skills
- Substance abuse

It should also be kept in mind that many clients do not only face one obstacle but instead are burdened with many problems simultaneously, so situations become even more difficult for these persons.

To gain a better understanding of the clientele these programs work with they were questioned as to approximate how many clients (the parents) out of every ten are in need of mental health services. One major finding was that for every ten clients met by these programs six and a half of them suffer from some sort of a mental illness (severity of illness varies). That is a large percentage to be found amongst these families, showing that mental illness is a major stressor for families. The social workers were also asked what the most prevalent mental health issues they witnessed in clients were. The top five responses were:

- Depression
- Bi-polar disorder
- Anxiety
- Post Traumatic Stress disorder
- Oppositional Defiant disorder

Depression was mentioned most frequently amongst the professionals as a mental health issue faced by their client population. When asked if depression was an illness rarely, sometimes, commonly, or prevalently suffered by their clientele, everyone agreed that it was a commonality among their clients.

To gain a better understanding of how these clients feel on a daily basis the professionals were asked to describe the way their clients describe their depression. Commonalities were found in the descriptions which included lack of energy for daily activities, feelings of worthlessness/hopelessness, sadness, feelings of failure as a parent, not wanting to get out of bed, ect. From here the social workers were asked to share what effects they observed their client's depression had on their parenting abilities. These were the effects that were agreed upon:

- Difficulty setting limits and poor follow through
- No motivation, find it difficult to stimulate their own children when they are so sad and feel so overwhelmed/stretched (due to multiple stressors)
- Their increased tiredness leaves them unable to spend time with the children and provide them with adequate nurturing
- Emotional unavailability
- Cannot focus on children's needs because they cannot meet their own
- May take feelings out on children
- Increased risk for substance abuse
- Do not want to "deal" with children
- Decreased patience
- Lack of supervision in home

- Unable to provide “normal/healthy” social interactions for children
- Lack of involvement in daily activities

These are some of the main observations of negative effects depression has on someone’s parenting ability. An interesting finding among many of the responses was that many parents, although having difficulties raising their children, find great strength in them. For many parents their children are the only thing that keeps them going and actually provides motivation in contradiction to their emotional/mental health problems. It is also important to note the observed effects on the children of parents who suffer from depression. Among the effects on children identified by the social workers are:

- May blame themselves for their parents unhappiness
- May feel worthless or blamed for everything
- Treated harshly
- Children might also suffer from a mental illness
- Children may develop behavioral problems (acting out their own feelings in negative ways) or anger issues
- May not develop proper coping skills, emotional maturity
- Lack of healthy parent/child interactions
- Low self-esteem
- Seeking out affection in unhealthy manners
- Loss of childhood, inappropriate role assignment
- Trust issues

These are some of the noted negative effects that the social workers have observed in their clients. One thing to keep in mind is that the effects on the children depend on how

their parent handles their depression. Some factors to keep in mind are whether the parent is on medication, if they understand their illness, if the child understands the illness, how the parents express their emotions, etc. Without a parental figure to turn, whom to the child is not given a positive role model. Not every child who has a depressed parent will have major emotional and behavioral problems', some children may be able to find other resources for strength and support, but many may feel the effects of not having the proper nurture and care they needed to grow emotionally healthy. It may also be difficult for children in these circumstances to find outside support because often there are other family members who suffer from similar or the same mental health issues leaving them with a smaller pool of adults to turn to.

Another important part of this research was to explore the problems these clients experienced when they attempt to access resources and what kinds of resources would be most helpful to them. Social workers identified the following steps they take when trying to assist a client who suffers from a depressive disorder:

- Work towards a trusting client/clinician relationship
- Evaluate need for medication and severity of diagnosis
- Make referrals for appropriate psychiatric evaluation/care/counseling
- Assess for suicidal/homicidal ideations to secure the safety of the client
- Provide support, listen, and be understanding to their predicament
- Teach client about their symptoms and ways to manage them
- Learn about the different medications and help client to understand their medication regimen and its effects
- Make a plan for self-care, stress management, and symptom management

- Educate client on how their mental illness can affect their children and life
- Try to alleviate outside stressors that could be contributing to the depression by linking client to resources and sorting out problems
- Use support groups as a resource
- Challenge clients to discover their own strengths, learn what they have control over and how to let go of things they do not, teach healthy coping skills

One of the main focuses for these clinicians was to build a trusting relationship with the client. Many noted that in order to accomplish anything they felt it necessary to establish that the client could trust them and the importance of honesty in their work. Also the findings show that one of the greatest benefits to seeking help from programs such as these is their ability to provide stable support. Many parents who face so many stressors in life are also plagued with not having a support system to turn to in times of need, whether it is for resources or simply to express themselves and their emotions. These clinicians provide that outlet for a healthy release of stresses and feelings that most people can find in friends and family. Unfortunately for the clients of these programs and those seeking similar services, problems tend to pile up and they are not always surrounded by a supportive network of loved ones.

Although there are resources available (limited but they do exist) to those who need assistance for mental illnesses, many do not utilize them. There are many obstacles preventing the utilization of mental health resources. The targeted social workers brought up these as some of the main obstacles preventing the clients from accessing resources:

- Many clients are underinsured or have no insurance

- Lack of transportation
- Lack of knowledge on how to access resources
- Navigating paperwork and red tape
- Leaving the house/following through with appointments
- Difficulty finding available mental health resources
- Lack of motivation (due to depression)
- Negative experiences with mental health services in the past
- Lack of bi-lingual mental health clinicians
- Illegal status of clients (not citizens)
- Childcare
- Fear and resistance of the client

The target group was then asked what changes they would like to see implemented to make the mental health system more equipped to help those it is supposed to be serving.

These were the changes they thought would be beneficial to the system:

- Availability of free clinics for those that are not insured/underinsured
- In-home therapy/program
- Childcare
- Increase the number of bi-lingual clinicians
- Access to transportation for clients
- Make services easier to access and obtain
- Sensitivity training for clinicians to prevent negative judgments and attitudes towards the clients
- Using group therapy and education as a tool more often in the counseling process

These are all large changes to propose but they would be beneficial to the system. These social workers and others in various programs are witnesses to what prevent the clients they see from seeking help (not to mention those that never make it out their door). These changes should be considered for the benefit of the mental health system.

### *Conclusion*

After reviewing the findings from the research and the literature review it would be difficult to doubt the statement that a parent suffering from depression or bi-polar disorder would have difficulty providing adequate, healthy nurturance to their children. Mental illness has a profound effect on the with the disorder and causes a wide spectrum of symptoms and effects. This is not to say that someone who suffers from a mental disorder is not a good parent, but that their parenting abilities could be compromised due to their illness; however, these parents can often effectively parent when appropriate services are sought.

It is necessary to remember that mental illness does not just affect the person inflicted with the problem but it affects the entire family, especially the children. Although resilient, children still need a strong and caring parent. They depend on the love and nurturance of their parent to teach them about the world and guide their growth. When a parent suffers from a mental disorder there is a possibility that the parent's needs will come before the needs of the child, and that becomes dangerous for the health and development of the child. It is unfortunately understandable that a parent who can not seem to handle their own problems would not be able to direct the life of someone else. The effects these situations can have on the children vary greatly as the findings show. A large factor involved is how the parent behaves, how the mental illness is understood, and how severe it is. Children can experience a wide range of effects; they often act out their emotions because they are unable to express them in another way. Working with someone with a mental illness means working with those surrounding them as well, especially when they have children who are their sole responsibility.

The research findings provide a wonderful opportunity to observe the work of programs that try and work with the entire family using outreach services. The micro implications of these research findings show us how programs such as these seem to be successful for this target population. These types of programs such as CES allow the social worker more access to the family and their surrounding environment; this provides a family system perspective to guide the intervention. The process used by the program builds off the trust established from the first meeting so that the worker can inquire about the client's personal feelings, which often do include sadness and depression. The research demonstrates how important it is to notice the surrounding systems in a client's life. A person's mental stability is often affected by the events of their lives. When a person is inundated with pressures and stress factors in their lives, it is not surprising if they become upset or depressed. Stressors might also trigger mental health problems that a person already suffers from, complicating the situation and making it worse. It is important to remember that all factors are interconnected in some way, and when working with a client the focus can not just be in one area while dismissing the rest. There needs to be a wide vision of the problem and situation so that goals can be set that work towards the larger picture.

In regards to the macro level implications, many of the obstacles faced on a personal basis by the clients of these programs and on a large scale faced by the mental health community became apparent. It becomes evident that services for the mentally ill are severely lacking. There are not nearly enough services available to those that need them, often there are extensive waiting lists, there are financial constraints, and often the services that are available are not adequate and do not meet the needs of the clients. So

many changes need to be made to our system in order to make mental health services better able to serve the community. As social workers we all might have the opportunity of working with members of this community and have to attempt to link them to services. One would quickly learn that connecting someone to counseling is not an easy task; there are many barriers and red tape to get through simply to get someone into a program. There are not enough resources as well, making receiving services almost a competition as to whose client is worse off. These are obstacles we shall face while trying to help clients. Major changes need to be implemented to our system that allow for faster and more efficient use of services. Adequate services need to be provided and made known to the populations that need them. Also the process needs to be made easier to navigate, because people that need help might easily be turned off from seeking aid if help does not even appear in their grasp.

We also have to be sensitive to the condition of our clients. Before going to judge a situation it is the social worker's responsibility to assess the whole situation. Of course it is important to check for safety because that is our number one concern for any children we meet, but in addition we want to work with the family. If a parent suffers from a mental illness, it is our job to link them with resources and aid them in any way we can. We are also responsible for curtailing stereotypes that are ingrained in our society. We must look past the judgments made on the mentally ill and try to help people to our best capacity while setting a good example of how to treat people. Most of all we need to treat the mentally ill like normal people who suffer from a medical disorder. Yes, there are differences that have to be kept in mind, but mental disorders are illnesses. We need

to work with this community to help them and fight for their rights to seek needed resources.

In order to bring together more substantial data a more comprehensive inquiry can be done into various service agencies that serve the mental health community. It might be wise to begin the research focused solely on agencies that work with the family system. It might also be beneficial to seek out other agencies that work with those who are affected by mental health disorders, particularly depression. It would also be beneficial to interview clients to understand more about the personal affects of mental illness, what has helped them, what services have not been of good use, and what they think would be beneficial. From what is learned different programs can be planned to better meet the needs of depressed parents. These needs and risks can be documented and used to argue for more funding for mental health services and to plan for better, more comprehensive services. Research should also be done regarding the number of people whose mental health needs are not met, due to waiting lists and lack of available resources and to find out the extent of the need of each area. Creating a prototype of a program using the findings and results might also be beneficial in order to test the data that were compiled. There are so many things that need to be done and so many directions to take this research in. The best place to begin is by compiling more research and using all of the information to work on making changes in the community. Steps come before leaps, and leaps before bounds; with patience, drive, and heart we can make changes happen for those that need a little extra help.

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## Survey

How many years have you worked for Gateway Healthcare?

How many years have you worked in the CES program?

How many years have you been a social worker?

What other agencies have you been employed in?

Please explain the clientele you serve in the Comprehensive Emergency Services program:

What are some common reasons/problems why people are referred to the CES program?

What are some of the major obstacles parents face in their abilities to care for their children properly (be as specific as possible)?

How often are clients referred and are in need of mental health services (approximately out of every ten clients how many)?

1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Additional comments:

What are the most prevalent mental health issues faced by the clientele of the CES program? Please list top five:

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

Would you consider depression an illness rarely, sometimes, commonly, or prevalently suffered by the clients served by the CES program?

Please explain your answer:

How do the clients that suffer from depression usually describe the way they feel (try to use descriptions heard from clients)?

What are some ways that you have observed how depression has affected the parenting skills of clients (please be specific)?

From what you have observed working with clients what effects if any are had on the children of parents who suffer from a depressive disorder?

Do you find that there are usually other family members (extended family included) who also suffer from a depressive disorder?

What are outside and environmental factors that might affect the mental status of these clients (that might contribute to their depression)?

What steps do you take as a social worker to assist a client who suffers from a depressive disorder?

What are the biggest obstacles to seeking assistance for clients facing these problems?

What if anything would you like to see change in the mental health system to make it better equipped to help those who suffer from mental health disorders?

If you feel comfortable and while keeping in mind confidentiality, please provide examples of clients you have worked with who have dealt with such issues as depression/bi-polar disorder and explain how it affected the family system and their abilities to parent their children:

Diagram #1

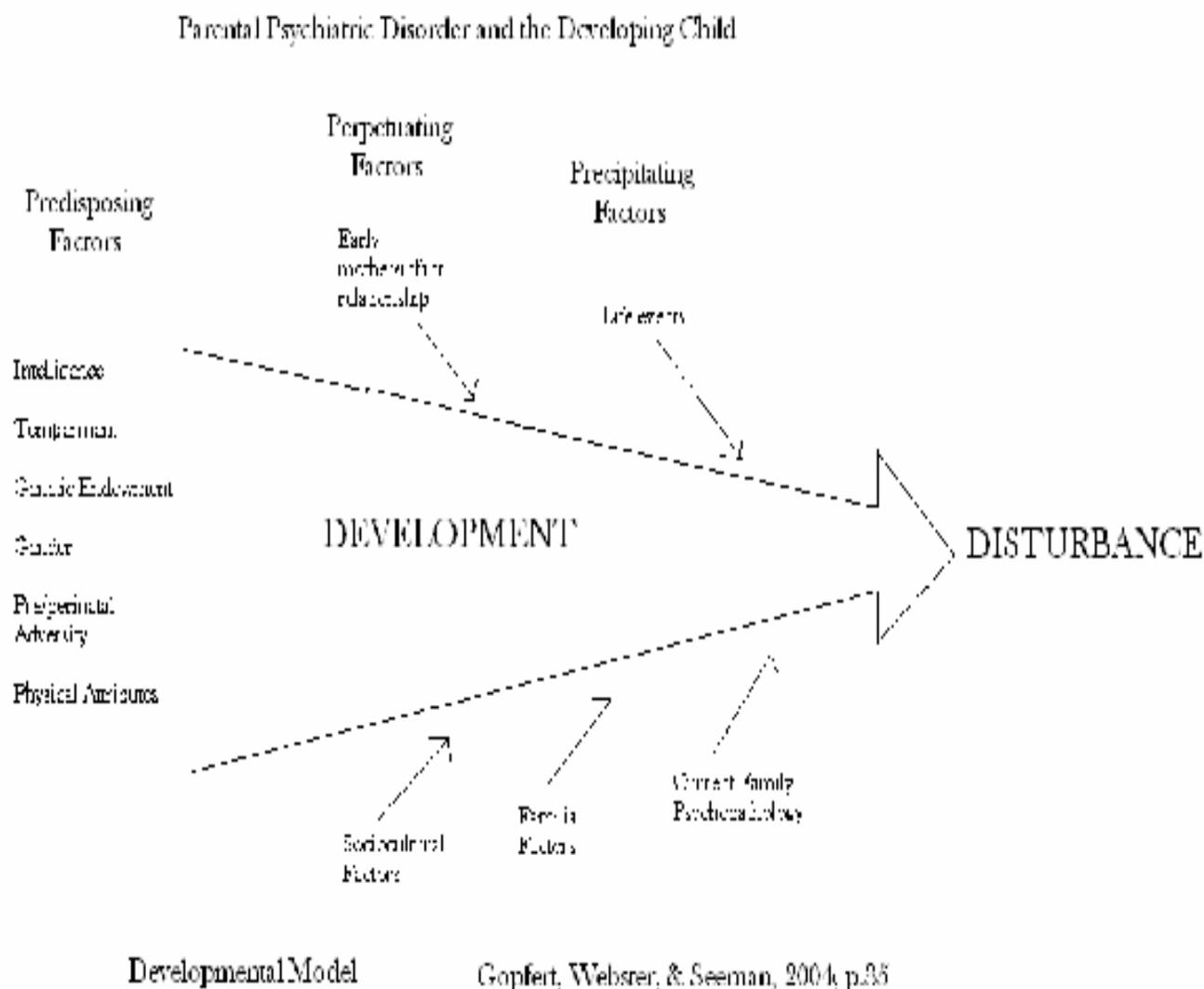
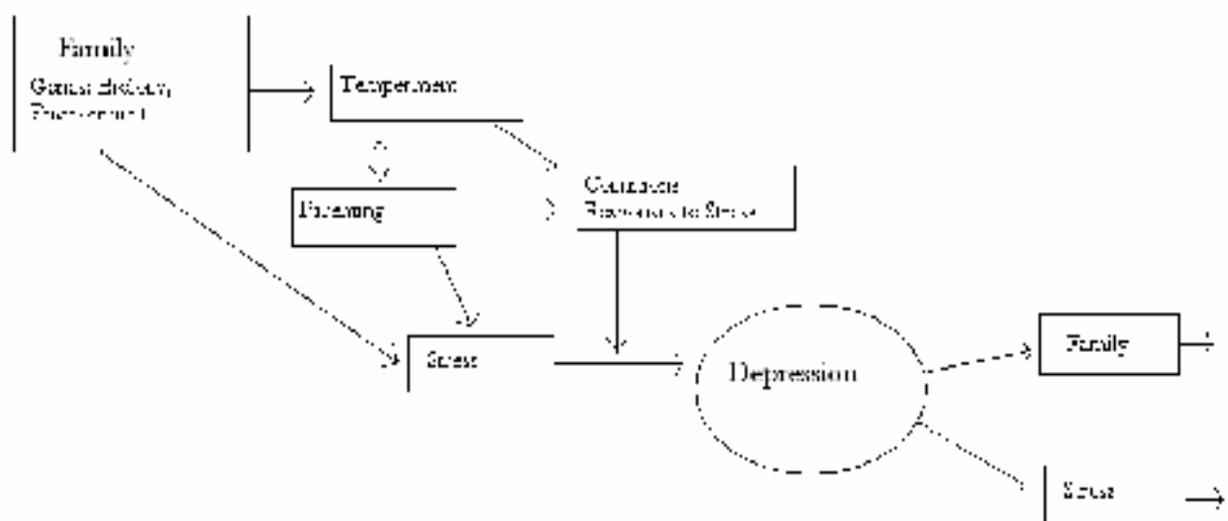


Diagram #2



A biopsychosocial framework of the relation between the family and depression

Hudson & Rapee, 2005, p.227